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ABSTRACT

Rehabilitation psychology and medicine are growing rapidly and can provide rehabilitation psychologists many opportunities for the integration of psychological approaches with adjustment realities resulting from client functional limitations. This paper discusses significant developments in rehabilitation counseling in medical settings over the past 10 years and explores some projected future directions which will provide challenges to the rehabilitation counselor or psychologist. It looks at rehabilitation techniques such as ego enhancement through the use of imagery and hypnotic techniques in a modern rehabilitation setting. Ego building, stress reduction, and creative-realistic goal formation are described as building blocks for the rehabilitation client's unique fulfillment and as helpful tools to be used in the counseling process. These techniques are described and case examples are given of clients with whom they were used. The paper concludes with a proposal for integrating rehabilitation adjustment and hypnosis. Rehabilitation counselors are encouraged to espouse carefully planned, positive goals; collect evidence to justify innovative programs; and continue to support development of the professional foundation of rehabilitation with statistical research and documented clinical experience. (NB)

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Developments in Rehabilitation

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Challenging Developments in Rehabilitation Counseling

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Running head: CHALLENGING DEVELOPMENTS IN REHABILITATION

Abstract

Rehabilitation psychology and medicine are growing rapidly and can provide the rehabilitation psychologist many opportunities for integration of psychological approaches with adjustment realities resulting from client functional limitations. Using dynamic imagery in a developing therapeutic process, coinciding with the client's psychological rehabilitation progression, the present author presents a proposal balancing rehabilitation adjustment and self-esteem building hypnosis, based upon her medical setting experience and integration of the literature. After a discussion of major rehabilitation developments in the last decade, projected developments and challenging resources for the modern day rehabilitation counselor are presented.

Challenging Developments
in Rehabilitation Counseling

Significant developments in Rehabilitation Counseling in medical settings over the last 10 years will be discussed, along with projected future directions, providing challenging resources for the modern day rehabilitation counselor or psychologist. There will be exploration of ego enhancement through the use of imagery and hypnotic techniques in a modern rehabilitation setting. Ego building, stress reduction, and creative-realistic goal formation are all building blocks for the rehabilitation client's unique fulfillment, as well as helpful tools to be used in the counseling process.

I will be sharing some of my personal observations as a counseling psychologist at a large general medical Veterans Affairs (formerly Veterans Administration) hospital, Hines VA Hospital, where I have worked with persons who are being treated for substance abuse, spinal cord injury, and patients with a wide variety

of medical problems. Hines is approximately a 1200 bed hospital with 22 staff psychologists, and the Department of Veterans Affairs often has initiated pilot projects in rehabilitation at our Spinal Cord Injury Service and Blind Rehabilitation Center. At the same time, psychosocial rehabilitation at Hines is a microcosm of mainstream psychosocial developments within the rehabilitation field.

Significant Developments in Rehabilitation Counseling

Over the Last Decade

Over the last decade in a hospital setting, I have observed the following eight major trends in the field of rehabilitation. They represent better direct care for individuals with disabilities, as well as better integration among professionals who are using concentrated, coordinated team efforts. Often I will be talking on the basis of what I have seen occurring at Hines Spinal Cord Injury Service.

1. There has been a major independent living movement, which includes development of a hospital-based Spinal Cord Home Care

Program, technology-related assistance, and outpatient follow-up. In Home Care, emphasis is upon physicians, social workers, various specialists in nursing, et al. working cooperatively with the family/caregiver(s) to maintain the patient in a home setting rather than a hospital setting; the patient is considered a valid, working member of the health care team. Also, technology has been developing into an effective means of assisting persons with disabilities through use of computers and computerized equipment in the home environment. In some cases, when intensive medical care is not required, follow-up through an outpatient clinic may be appropriate.

2. There has emerged a focus on cost-effective rehabilitation. Hospital stay has been reduced, often 1/2 to 1/3 the length of time required in the early 70s. Staffing by a board of team members is used to set clearcut objectives for rehabilitation within a specified time span. During this staffing, numerous professionals share observations and conjointly set treatment goals, which are then finalized when the patient joins the meeting.

3. Over the years, there has developed an increasingly coordinated interdisciplinary team effort, with intellectual integration of varied specialties. Information is shared equally across disciplines. We are realizing that emotional integration of our human aspects as staff members is very important. Paired staff members, blending disciplines, can do therapy together, balancing each other's weak points and receiving mutual support. The rehabilitation model is an interdisciplinary model with acknowledgment that realistic treatment plans cut across disciplines in dealing with the client as a whole person and that professionals must share their expertise.

4. The growth of the rehabilitation point of view, focusing upon the strengths and goals of the client, has been vital to accomplishment of worthwhile therapeutic results. The person with a disability has a future, is worthy of a good education, and can contribute both socially and vocationally to society.

5. I find more staff respect for the knowledge and perspective of

the client. Providing input during the planning period, clients have become better educated about their injuries and more clearly are functioning members of the rehabilitation team.

6. Peer counseling has been developed into a viable therapeutic approach. At Hines, we have a training program on Spinal Cord Injury Service for rehabilitated peer counselors, who wish to counsel and assist those who are newly injured. Also, Paralyzed Veterans of America, a veterans' organization, is a fine example of persons with spinal cord injury helping their peers through individualized counseling, as well as developing major, worthwhile directions, often of a legislative nature.

7. In my opinion, the most interesting, creative aspect is the growth of varied psychosocial specialties enabling psychologists to make unique contributions to life enhancement and constructive adjustment. Examples of such treatments are pain control as a team effort, sexual dysfunction therapy, relaxation and stress reduction, a wide variety of imagery techniques, and self-hypnosis including ego

building techniques. Self-hypnosis may be used creatively to improve the client's outlook on self and environmental prospects and, when appropriate, to integrate multiple selves which are conflicting with one another rather than cooperating. It is possible that debilitating physical injury may induce a protective creation of multiple selves, a splitting related to the pre- and post-injury self-images. With ego building imagery, by dreaming the near-to-impossible dream, clients may make their lives a self-fulfilling prophecy based upon their goal expectations and thereby obtain "the dream," their cherished goal(s).

To meet a wide range of client needs, the Hines VA Psychology Department internship training program includes many specialties. Examples of these unique approaches are family therapy, marital therapy, gerontological counseling, chronic pain control, cognitive behavior skills, sexual dysfunction, hypnosis, crisis-gearred intervention techniques, and neuropsychological assessment.

8. Continuing development of realistic client nurturance and guidance has been an important contribution to counseling

effectiveness. According to Cholden (1958), when guidance is used to release the client's desire to grow, it is not a bad process. Since inherent motivation is already there, the counselor's concern must be directed toward removing the blocks to full utilization of the client's inherent motivations. The professional effort is focused upon the release of often powerful blocking forces in the client. These possible blocking forces are feelings of nonacceptance by society, dependency desires reinforced by society and/or the counselor, and stereotyped attitudes toward the disability. As counselors, we believe in the client's desire to change, typically released after removal of the blocks that lie in the path of the full utilization of individualized motivations.

In many cases, the individual with disability needs the feeling that friendly and interested people believe in his/her desire and ability to change. Therefore, counselor follow-up and expressed commitment to client welfare is very important. Counselors become facilitators who maintain concern and convey it to the patient

therapeutically through healing communication.

In Super's model of career guidance (1969 and 1983), counseling is used to provide guidance of development rather than mere assistance in decision making. The counselor is a facilitator, emphasizing the importance of exploratory behavior in preparation for career choice and development. This model can be applied to rehabilitation in general. Curnow (1989) explained that limited early experiences, difficulty in decision making, and a poor self-concept have impact upon the development of many persons with disabilities. Thus, to facilitate life development, the counselor must consider the client's background experience, ability to decide, and existing self-concept and deal with these attributes in therapy.

Future Directions in Rehabilitation Counseling

Of course, there will be continuation and refinement of the developments already discussed. In addition, there are numerous new potential developments, requiring creative therapeutic expertise on the part of the counselor.

1. There will be more emphasis upon substance abuse counseling plus rehabilitation of whatever physical and/or mental functional limitations concurrently exist. Often clients have multiple concerns, not to be ignored or oversimplified. This means counselors must be multifaceted and develop referral expertise as well as facility with their own specialty, and they must know which major direction to pursue at any given time.

Acquired immune deficiency syndrome (AIDS) can frequently occur in combination with various other rehabilitation concerns, such as substance abuse and serious emotional functional limitations. According to Klecolt-Glaser and Glaser (1988), there is good evidence for psychological mediation of immune function, and psychosocial or behavioral variables are among possible cofactors influencing human immunodeficiency virus (HIV) infection and disease progression.

At the Illinois Institute on Drugs and Alcohol Conference, Cebuhar (1989) spoke about linkage between substance abuse and HIV infection. He recommended stress management techniques, aerobics,

biofeedback, self-hypnosis, imagery, relaxation, peer support, and good nutrition as potentially contributing to the better adjustment of persons who are HIV infected or persons who have AIDS. In the medical arena, psychology's most progressive techniques can be brought into play, and further research is needed to guide development of these approaches.

I believe that working with psychological influences on wellness and immunity will be the major movement within the discipline of psychology throughout the 90s. Clients will take a more active role in their own "psychomedical" treatment, and behavioral assistance techniques will become more applicable to physical concerns. Rossi and Cheek (1988) and Fezler (1989) explained this new psychosomatic medicine, in which mind-body communication through created hypnotic images promotes healing. Also, Rossman (1987) described a hypnotic script, "listening to your symptoms," where the client is to image the symptom and negotiate with it, learn from it, and appreciate it.

2. It is hoped that there will be more help for staff members who are overstressed because of draining demands in their work setting. Wellness of staff, not just client, should be fostered and studied. Work setting territoriality should be minimized, with staff relating to one another in an understanding, cooperative manner. Rehabilitation counselors cannot be Olympian figures of authority but must share their human qualities and strength reserves with suffering, needy persons. This can be both very rewarding and very draining emotionally, sometimes in a subtle, almost imperceptible, continuous progression as the years go by and cases build up. Therefore, counselors as well as clients need stress management and support.

3. Increasingly clients and professional advocates may need to fight to counter a misguided emphasis on cost effectiveness. Often professionals have valid ideas about allocation of money in rehabilitation settings well ahead of societal support and comprehension. Trieschmann (1988a) asserted that the role of the

rehabilitation psychologist is more critical than ever, since we need to join with other disciplines and consumer groups to try to change a system becoming less sensitive to the multiple needs of persons with disabilities. She recommended a bipartisan panel which would consist of people with disabilities, business people, politicians, health care professionals, and social planners reporting to the President regarding the financing of health care delivery and independent living. This panel would consider health care delivery across the life span and would evaluate long term consequences of health care management.

4. In the future, medical advances will influence counseling needs in dramatic ways. I look forward to a more complementary relationship between medical treatment and rehabilitation counseling. Since greatly improved scientific measurement techniques are now available (scientists can measure properties of single atoms through physical methods efficiently), perhaps eventually we will detect the beginning stages of developing

pathology, thereby achieving early diagnosis of many physical disorders. With an increasingly thorough understanding of genetics, doctors may diagnose many medical problems before any outward physical or psychological manifestations occur. Psychological mediation of immune function might then become very important for preventing disease as well as for controlling the course of disease.

5. The rehabilitation orientation which encompasses facilitation of client strength and better perfection of environmental support will spread more widely, especially to psychiatric rehabilitation. Along with therapeutic emphasis upon improving self-esteem, downplaying guilt, and facilitating personality development, there will be more recognition of the client's strong points. The client will be a full partner in this process, and his/her specialized needs will be addressed in light of environmental realities.

6. In hospital settings, rehabilitation case management will develop as a well-planned, wisely-staged progression. There will be more thorough documentation and exploration of the treatment plan.

Emphasis will be placed upon transition steps, supports, and a repertoire of practical resources related to specific client concerns. There may be more documentation of the treatment plan by a staff member who is in a central case management position. Emphasis will be upon vocational development, avocational aspects, family and/or significant person adjustment, resources for making choices, and the client's assumption of realistic responsibility in a complex world.

7. I am looking forward to the fruition of a renewed focus on fostering life enhancement, multiply defined as follows:

(a) Building of a healthy self-concept, through therapeutic efforts, will be better understood and more easily accomplished than today. This is likely to mean cooperative rebuilding of major aspects of the client's self-concept by staff and client and significant others, as well as use of better guiding theory for personality reconstruction.

(b) Vocational and leisure time counseling will become more important as a balanced undertaking related to the individual's uniqueness and special aspirations. Some clients will aspire to time

consuming attainment of vocational pursuits, whereas others will plan primarily for leisure time activities. Many clients need combined vocational-avocational counseling, where work and hobby goals are delicately balanced to provide client fulfillment.

(c) Rehabilitation counseling geared to various life developmental stages will be better understood and utilized. Crucial adjustment processes vary with developmental stages over the life span. Both short-run and the long-run repercussions of potential client choices will be considered during counseling.

(d) There will be increased knowledge of how to foster competence in the client's decision making ability. The client will develop expertise going beyond the making of a single decision to permit mature adjustment to choice-point demands throughout life.

(e) Specific client problems will be addressed by counselors with formidable, clinically researched approaches in areas including pain control techniques, imagery that enables reconstitution of constructive behavior, self-hypnosis for ego building, effective

stress management techniques, and reframing techniques for changing self-destructive behaviors into goal-oriented capabilities providing self-fulfillment. Krause and Crewe (1987) presented research findings which suggest a need for more intensive psychosocial rehabilitation, because persons with spinal cord injury who were more active socially and vocationally were more likely to be alive eleven years following the initial survey. It is likely new developments in clinical techniques will be put to good use, making life more rewarding for clients with spinal cord injury.

Of these various techniques, I am most interested in use of creative imagery and self-hypnosis in a medical setting to provide resources for ego or self-esteem building, for anxiety reduction, and for mature adjustment. Physical and emotional healing through use of guided imagery is on the leading edge of contemporary health care (McDowell, Bills & Eaton, 1989).

Use of Relaxation, Imagery, and Self-Hypnosis in
Self-Esteem Building During Rehabilitation

What is the typical adjustment process during rehabilitation?

Stage theory of adjustment has been around for many years, but according to Trieschmann (1988b) writing about spinal cord injury, stage theory has been discredited as the exclusive conceptualization of coping. Rather social scientists are now making allowance for diversity of response and recognizing some individuals may be more or less depressed than others, may use denial more strongly than others, and so on. Regardless, a counselor often recognizes certain common client feeling states which when fully developed (a) often start with withdrawal, grief, and denial; (b) then proceed to depression, disorganization, and despair; and (c) eventually stabilize, sometimes after a reaction against dependency, into a reconstitution of the pretraumatic personality.

Choice of visualized imagery and hypnotic techniques along with appropriate timing are proposed as the counselor's strategic

therapeutic response to the client's emotional state. The present author's hypnotherapeutic approach is based upon her clinical experience and upon the publications of Klich and Miller (1989), Stanton (1977a, 1977b, 1987, 1989), Borysenko (1987, 1989), Fanning (1988), and Fezler (1989).

Klich and Miller (1989) proposed using rehabilitative hypnotic suggestions and positive imagery to accomplish self-esteem building in the rehabilitation client experiencing negative feelings about debilitating loss. Thus, the client was primed for positive response to "prestige suggestions" of the therapist, providing an atmosphere of nurturance and respect. Very important is cogent, positive wording used hypnotically to embed a sense of worth, confidence, and success, both formally and informally, consciously and subconsciously. Self-hypnosis is taught within the context of the therapeutic process, and it is established as a mechanism for positive self-growth through integration of positive self-image into eventual behavior.

Initially the client is taught the nature of self-hypnosis and how

to relax by hypnotic methods. A variety of relaxation approaches are possible. Accompanied by imagery, deep breathing can be used to facilitate and trigger relaxation and to increase the client's sense of physical well-being (Borysenko, 1987). Stanton (1977a) proposes that breathing can be used as a form of energy transfusion. He encourages the client to drift into a relaxed, dreamy state and to imagine that energy in the form of white light is being drawn in through the nose during inhalation to radiate or focus within the body in a re-energizing manner. Many other examples of initial relaxation procedures could be given; the most classic of which would be the well-known Jacobson's Progressive Relaxation, a technique involving progressive tensing and relaxing of major muscle groups.

As part of on-going therapy, guided imagery visualization is useful to help clients utilize their various underused sensory modalities, thus breaking out of concrete, rigid, depressive patterns into mental states conducive to positive change. However, before directly building self-esteem in the client, it may be beneficial to

use guided imagery to assist the client in dissipating despair and countering repressed, negative, internal self-connnotations and communications.

During hypnosis using imagery, clients can be invited to imagine themselves dumping fears, doubts, worries, and guilts down a chute from which nothing can return or placing their negativities into a hot air balloon that lifts away (Stanton, 1987, 1989; Alman, 1983). This approach is morale building and encourages clients to feel they have creative resources to tackle their own problems.

Also, barrier removal imagery (Stanton, 1977a, 1989) may be helpful in self-hypnosis. The client is assisted in visualizing a brick wall blocking him/her from realizing full potentiality. Then, using much sensory detail, the client visualizes exploding the wall; this imagery may symbolically serve to neutralize any externalized hostility or blame. Barriers, representing self-destructive thoughts, mental obstacles, and self-imposed limitations, are destroyed in imagination.

Thought stopping and thought switching is often useful; for example, the client can visualize a neon sign flashing on and off or a stop sign when negative self-thoughts begin to occur. The client is encouraged to think the exact opposite of the negative thought. Eventually clients may develop their own imagery to provide release from negative feeling states by choosing whatever visualization seems best to them.

In hypnosis, according to Klich and Miller (1989), the client can say necessary goodbyes to a destroyed body part, as the therapist maps a metaphoric scenario for the leave taking. It may be necessary to say goodbye to family members, unreachable ideals, and unattainable dreams, as well. The necessary farewells are followed by positive images based upon realistic hopes for the future. These positive images or self-affirmations can be designed to counterbalance what was lost.

After the therapist deals with the client's depression, disorganization, and despair, client independence may be fostered by

assisting him/her in creating a personally-designed, safe existence. Elton and Burrows (1978) described use of specific imagery to create a "secret room." The secret room, a retreat from the outer world, is custom-built in imagination for maximal pleasure, satisfaction, comfort, and security. I have found this approach to be effective with persons wanting independence from controlling identification figures who have taken over leadership from the client in times of crisis. Not all clients will profit from this approach to the same degree; the therapist makes a judgment about its usefulness on the basis of known client background and personality information.

Joe, 35, suffering from learning disability and substance abuse, still living with his parents, was encouraged to visualize his own special room. He created his custom-designed haven, furnished as he wanted it to be. He described it as providing him with feelings of safety, security, and relaxation. When pressured by parental demands, he would visualize his special place to calm himself down and dissipate feelings of despair and anxiety. Now Joe is planning a

college education and thinking about moving into his own apartment.

Wright (1983) stated that the assets of the person must receive considerable attention in the rehabilitation effort. Hypnotic ego building suggestions can be used in influencing the person's feelings about self and future prospects; and thus, the negative significance of disability can be lessened in the client's mind. For the most profound therapeutic effect, positive suggestions and descriptions, combining vivid sensory modalities, are always presented in the present tense. In a similar vein, Stanton (1977b) described two approaches to positive-suggestion therapy, those of Ellis and Hartland, both of which serve an ego-building function.

I use positive imagery, often custom designed in cooperative effort between client and therapist, so that the imagery has special meaning to the client. Tom, a 32-year-old veteran with Guillain-Barre syndrome and lacking in self-confidence as well as sense of accomplishment, wanted to plan a new career but had first to overcome many negative self-feelings. After counseling

exploration of veteran's self-talk, I taught him to use positive affirmations during self-hypnosis. He was encouraged to state what he wished to be like in the present tense, "I am hopeful, and I feel at ease, calm, and even tempered." Nots and negatives were avoided, as were references to past or future states. Increasingly during counseling, his goals were placed in definite statements and worded as accomplished fact. The client, who expressed much sibling rivalry, was encouraged to think in noncompetitive terms, avoiding words like "better", "best", "least", and "most". As counseling progressed, he was taught to add more sensory elements to his positive affirmations, making these thoughts come alive in his experience and memory.

In a management setting, Araoz (1984) initially elicited the client's negative affirmations, with associated negative imagery, followed by counteracting positive statements and positive imagery to be used during self-hypnosis. During mental reprogramming, the client first recognized negative thinking, then stopped it with positive self-suggestions.

Especially for the person with disability, who feels extreme loss from self-image and goal disruption, positive goal visualization imagery, with rehearsal of steps to obtain goal(s), leads to rewarding outcomes in many cases. Visualization can represent fulfillment of sexual desires, vocational aspirations, interpersonal relationships, avocational pursuits, and various desirable achievements.

C. H. Lankton (1983) shaped perceptions of future desired goals in the mind of the client by having the client step into the future picture and experience being there in the present tense, then daydream back, reviewing steps to goal accomplishment. The client first appreciated the future time and then reoriented to the present actualities.

According to Fanning (1988), time is simultaneous in the imagination, not sequential; therefore, during visualization, the person can skip ahead in the story or flash back to earlier parts of the script. Activated, the intuitive side of the brain makes time-independent connections for the client's benefit.

Return of creativity is fostered by means of rehearsing

beginning, intermediate, and advanced steps leading to the desired goal. Providing nurturing support within the hypnotic setting, the counselor helps the client develop pride and reactivate creative mental processes which have been dormant or underdeveloped.

Wright (1987) discussed future-time projection under hypnosis as an affirmation of hope when therapeutic encouragement was given the client. Reorientation to a future setting provides the interesting clinical possibility that the client will bypass early stages of psychological immobilization and become mobilized through coping exploration in protected practice.

Fanning (1988) described programmed self-esteem visualizations used to improve self-image. The client is told:

- (1) visualize overt behavior which relates to increasing your feelings of self-esteem, such as volunteering for a difficult assignment;
- (2) see yourself making small, positive steps toward a desired goal;
- (3) see the positive consequences of higher self-esteem, such as work success, achievement of goals, and satisfying relationships;

(4) include assertive body language reflecting high self-esteem; (5) see yourself struggling and then succeeding; (6) visualize liking "you" more; (7) tell yourself, "I am O.K. just as I am right now;" (8) in vivid sensory detail, see yourself discovering your self-esteem like a refound treasure with which you were out of touch; (9) repeat affirmations during visualizations that describe positive self-attributes in the present tense.

Emily, 42, a college lecturer in psychology, who was successfully recovering from a long bout with cancer, found it difficult to avoid negative mental rehearsal about loss of her youth and about what to do should her physical condition reverse itself. She expressed hopes of rekindling positive future goals and expectations. Using a hypnosis technique adapted from Borysenko (1989) and Rossman (1987), I invited Emily to count down from 3 to 0 and then have the zero elongate into a mirror in which she allowed the image of a wise, kind inner advisor to appear. The inner advisor presented Emily with a gift box containing what she most needed to know or

have.

In the gift box, much to her initial surprise, Emily found simply a pen. In discussing her hypnotic experience, Emily said she began to feel a deep, growing sense of self, as well as challenge, and that her strength reserves and feelings of being in control welled up inside her, as she envisioned picking up the pen and proceeding with positive plans for her future.

In another session, under hypnosis, Emily was asked to shape perceptions of her desired future goals, using the pen as organizing symbol, since she felt it had significant meaning. The client stepped into a future picture where she visualized earning her first major publication, providing occupational security and her most cherished goal, a secure, independent career. She daydreamed back, reviewing steps to goal accomplishment, in which she planned to tackle writing and related professional and physical self-improvement in realistic, sequential, well-planned steps. She terminated the fantasy by first appreciating the future time and then reorienting to present

actualities. Soon Emily began a comprehensive self-improvement program to facilitate her literary endeavors, and eventually achieved the publication she so desired, along with increased self-confidence and a more optimistic outlook.

Many rehabilitation clients need a mental shot of boredom immunity; typically they have spent much time taking medical tests, awaiting these test results, and lying in beds recuperating. The juice of mental creativity injects boredom immunity and fosters development of positive self-affirmation along with activation of new behavior based upon making choices and upon taking control in a crisis situation.

Clinical and experimental evidence about the usefulness of ego-enhancement procedures in therapy has been growing as clinicians report positive clinical findings and as supporting research studies are published (Klich & Miller, 1989; Stanton, 1989). Certainly the importance of adequate self-concept has been well-documented in the literature. Additional carefully planned scientific studies would

be instrumental in further establishing the usefulness of hypnotic ego building in a rehabilitation setting. The following theoretical proposal could serve as a basis for such research.

**Author's Proposal Integrating Rehabilitation Adjustment
and Hypnosis**

Using dynamic imagery in a stepwise process, coinciding with the individual client's psychological progression toward psychomedical rehabilitation, the present author conceptualizes utilization of self-hypnosis within a rehabilitation setting. Not every client requires the same therapeutic emphasis, and some clients may skip or minimally show a common reaction, e.g., need for independence or projection of hostility, thus resulting in modification of how imagery is best presented.

However, in the full range of integration between rehabilitation adjustment and hypnosis, six phases predominate during therapy:

(1) Initially the client, often experiencing grief or denial, is taught to relax, learn relaxation inducing deep breathing techniques, and utilize

phantasmagoric imagery visualization in custom-designed self-hypnosis. (2) When experiencing depression or negative reactions, the client is encouraged to bring out disappointments, fears, and negative reactions and then to dump, stop, or destroy them. Necessary goodbyes to former expectations or self-perceptions may be said. (3) Barrier removal imagery may be used to annihilate self-destructive thoughts and mental obstacles. (4) Enjoyment of a special, imagined place sets a positive tone, fostering independence and conveying feelings of self-worth and control to the client. (5) Through positive self-statement under hypnosis, the client experiences personal growth resulting in ego enhancement. (6) Vivid, detailed, positive goal visualization, with rehearsal of steps to accomplishment, is important as the rehabilitation client returns to relatively normal personality organization and assumes self-responsibility as much as is possible.

Conclusion

Insights in rehabilitation psychology and medicine are growing rapidly and can provide the rehabilitation psychologist many opportunities for brilliant integration of psychological approaches with the distressing consequences of physical and/or mental functional limitations to lessen the burden of persons with disabilities. A true profession, rehabilitation counseling has evolved as a discipline with a wide ranging professional foundation based upon research, theory, and clinical expertise. Rehabilitation counselors should feel pride and persevere in working with each patient. Even beyond this, they should espouse carefully planned, positive goals, both in professional and public arenas; collect evidence to justify innovative programs; and continue supporting development of the professional foundation of rehabilitation with statistical research and documented clinical experience.

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